Complete Summary

GUIDELINE TITLE

Diabetes management in correctional institutions.

BIBLIOGRAPHIC SOURCE(S)

American Diabetes Association. Diabetes management in correctional institutions. Diabetes Care 2008 Jan;31 Suppl 1:S87-93. [15 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Diabetes Association. Diabetes management in correctional institutions. Diabetes Care 2007 Jan;30 Suppl 1:S77-84. [15 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Type 1 diabetes mellitus
- Type 2 diabetes mellitus
- Gestational diabetes mellitus
- Diabetes-related complications

GUIDELINE CATEGORY

Evaluation
Management
Prevention

Risk Assessment
Screening

CLINICAL SPECIALTY

Endocrinology
Family Practice
Internal Medicine
Nutrition
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Health Care Providers
Nurses
Optometrists
Physician Assistants
Physicians
Podiatrists
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide recommendations for diabetes management of children, adolescents, and adults with diabetes in the correctional institution setting

TARGET POPULATION

Incarcerated children, adolescents, and adults (including pregnant women) who have diabetes mellitus

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment/Screening/Evaluation

1. Reception screening to include:
    - Identification of inmates with diabetes currently using insulin therapy or at high risk for hypoglycemia
    - Screening capillary blood glucose (CBG) and urine ketone test (as clinically indicated)
    - Continue usual meal schedule and medication administration
2. Intake screening to include:
    - Type and duration of diabetes
    - Confirm current therapy
    - Presence of complications
    - Family history

- Pregnancy screen for all female patients of childbearing age with diabetes
- Assess alcohol use
- Identify behavioral health issues, such as depression, distress, suicidal ideation
- Assess prior diabetes education

3. Intake physical exam/laboratory complications screening
    - Complete exam including:
        - Height, weight
        - Blood pressure measurement
        - Eye (retinal) examination
        - Cardiovascular examination
        - Peripheral pulses
        - Foot inspection and neurologic examination
    - Laboratory studies:
        - Glycated hemoglobin (HbA1c) and glucose measurement
        - Lipid profile
        - Microalbumin screen (albumin-to-creatinine ratio)
        - Urine ketones (as clinically indicated)
        - Aspartate aminotransferase (AST)/alanine aminotransferase (ALT) (as clinically indicated)
        - Creatinine (as clinically indicated)

Treatment/Management/Prevention

1. Patient education regarding self management
2. Nutrition counseling and menu planning
3. Staff training to recognize and respond appropriately to urgent and emergency issues (e.g., hyperglycemia, hypoglycemia)
4. Medication administration (e.g., insulin)
5. Routine screening and management of diabetes complications including:
    - Foot care
        - Annual comprehensive foot exam
        - Special shoes as indicated
    - Retinopathy:
        - Annual retinal examination by licensed eye care professional
    - Nephropathy:
        - Annual spot urine test
        - Treatment with angiotensin converting enzyme (ACE) inhibitors/angiotensin receptor blockers as indicated
    - Cardiac
        - Blood pressure measurement
        - Lipid disorder testing
        - Aspirin therapy as indicated

6. Considerations for special populations (e.g., children, adolescents, and pregnant patients)
7. Referral to specialist as indicated (e.g., pregnant patients)
8. Monitoring/tests of glycemia (capillary blood glucose and glycated hemoglobin testing)
9. Transfer and discharge
    - Medical transfer summary

- Diabetes supplies and medication
- Continuity of care

MAJOR OUTCOMES CONSIDERED

- Prevalence of diabetes and diabetes-related complications among incarcerated population
- Health-outcomes in patients with diabetes

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

American Diabetes Association's Evidence Grading System for Clinical Practice Recommendations

A

Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including:

- Evidence from a well-conducted multicenter trial
- Evidence from a meta-analysis that incorporated quality ratings in the analysis
- Compelling non-experimental evidence (i.e., "all or none" rule developed by the Center for Evidence Based Medicine at Oxford*)

Supportive evidence from well-conducted randomized, controlled trials that are adequately powered, including:

- Evidence from a well-conducted trial at one or more institutions
- Evidence from a meta-analysis that incorporated quality ratings in the analysis

**Either all patients died before therapy and at least some survived with therapy, or some patients died without therapy and none died with therapy. Example: use of insulin in the treatment of diabetic ketoacidosis.*

B

Supportive evidence from well-conducted cohort studies, including:

- Evidence from a well-conducted prospective cohort study or registry
- Evidence from a well-conducted meta-analysis of cohort studies

Supportive evidence from a well-conducted case-control study

C

Supportive evidence from poorly controlled or uncontrolled studies, including:

- Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results
- Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)
- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations have been assigned ratings of A, B or C, depending on the quality of evidence (see "Rating Scheme for the Strength of the Evidence").

Expert opinion (E) is a separate category for recommendations in which there is as yet no evidence from clinical trials, in which clinical trials may be impractical, or in which there is conflicting evidence. Recommendations with an "A" rating are based on large, well-designed clinical trials or well done meta-analyses. Generally, these recommendations have the best chance of improving outcomes when applied to the population to which they are appropriate. Recommendations with lower levels of evidence may be equally important but are not as well supported.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The paper was revised by the American Diabetes Association/National Commission on Correctional Health Care Joint Working Group on Diabetes Guidelines for Correctional Institutions. It was reviewed and approved by the American Diabetes Association's Professional Practice Committee and Executive Committee of the Board of Directors.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The evidence grading system (A through C, E) is defined at the end of the "Major Recommendations" field.

Intake Medical Assessment

See figure 1 in the original guideline document for the essential components of the initial history and physical examination.

- Patients with a diagnosis of diabetes should have a complete medical history and undergo an intake physical examination by a licensed health professional in a timely manner. (E)
- Insulin-treated patients should have a capillary blood glucose (CBG) determination within 1 to 2 hours of arrival. (E)
- Medications and medical nutrition therapy (MNT) should be continued without interruption upon entry into the correctional environment. (E)

Screening for Diabetes

Consistent with the American Diabetes Association (ADA) Standards of Care, patients should be evaluated for diabetes risk factors at the intake physical and at appropriate times thereafter. Those who are at high risk should be considered for

blood glucose screening. If pregnant, a risk assessment for gestational diabetes mellitus (GDM) should be undertaken at the first prenatal visit. Patients with clinical characteristics consistent with a high risk for GDM should undergo glucose testing as soon as possible. High-risk women not found to have GDM at the initial screening and average-risk women should be tested between 24 and 28 weeks of gestation. For more detailed information on screening for both type 2 and GDM, see the National Guideline Clearinghouse (NGC) summaries of the ADA guidelines Testing for Prediabetes and Diabetes in Asymptomatic Patients, and Detection and Diagnosis of Gestational Diabetes Mellitus (GDM).

Management Plan

Summary of Recommendations for Glycemic, Blood Pressure, and Lipid Control for Adults with Diabetes

- Glycated hemoglobin (A1C): <7.0%*
- Blood Pressure: <130/80 mmHg
- Lipids
    - Low-density lipoprotein (LDL) cholesterol: <100 mg/dL (<2.6 mmol/L)**

*Referenced to a nondiabetic range of 4.0% to 6.0% using a Diabetes Control and Complications Trial (DCCT)-based assay.
**In individuals with overt cardiovascular disease (CVD), a lower LDL cholesterol goal of <70 mg/dL (1.8 mmol/L), using a high dose of a statin, is an option.

Urgent and Emergency Issues

- Train correctional staff in the recognition, treatment, and appropriate referral for hypo- and hyperglycemia. (E)
- Train appropriate staff to administer glucagon. (E)
- Train staff to recognize symptoms and signs of serious metabolic decompensation, and immediately refer the patient for appropriate medical care. (E)
- Institutions should implement a policy requiring staff to notify a physician of all CBG results outside of a specified range, as determined by the treating physician (e.g., <50 or >350 mg/dL). (E)
- Identify patients with type 1 diabetes who are at high risk for diabetic ketoacidosis (DKA). (E)

Medication

- Formularies should provide access to usual and customary oral medications and insulins to treat diabetes and related conditions. (E)
- Patients should have access to medication at dosing frequencies that are consistent with their treatment plan and medical direction. (E)
- Correctional institutions and police lock-ups should implement policies and procedures to diminish the risk of hypo- and hyperglycemia during off-site travel (e.g., court appearances). (E)

Routine Screening for and Management of Diabetes Complications

All patients with a diagnosis of diabetes should receive routine screening for diabetes-related complications, as detailed in the ADA's Standards of Care (See the NGC summary of the ADA guideline, Prevention and Management of Diabetes Complications). Interval chronic disease clinics for persons with diabetes provide an efficient mechanism to monitor patients for complications of diabetes. In this way, appropriate referrals to consultant specialists, such as optometrists/ophthalmologists, nephrologists, and cardiologists, can be made on an as needed basis and interval laboratory testing can be done.

The following complications should be considered.

- *Foot care*: Recommendations for foot care for patients with diabetes and no history of an open foot lesion are described in the ADA Standards of Care. A comprehensive foot examination is recommended annually for all patients with diabetes to identify risk factors predictive of ulcers and amputations. Persons with an insensate foot, an open foot lesion, or a history of such a lesion should be referred for evaluation by an appropriate licensed health professional (e.g., podiatrist or vascular surgeon). Special shoes should be provided as recommended by licensed health professionals to aid healing of foot lesions and to prevent development of new lesions.
- *Retinopathy*: Annual retinal examinations by a licensed eye care professional should be performed for all patients with diabetes, as recommended in the ADA Standards of Care. Visual changes that cannot be accounted for by acute changes in glycemic control require prompt evaluation by an eye care professional.
- *Nephropathy*: An annual spot urine test for determination of microalbumin-to-creatinine ratio should be performed. The use of angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers is recommended for all patients with albuminuria. Blood pressure should be controlled to <130/80 mmHg.
- *Cardiac*: People with type 2 diabetes are at a particularly high risk of coronary artery disease. Cardiovascular disease risk factor management is of demonstrated benefit in reducing this complication in patients with diabetes. Blood pressure should be measured at every routine diabetes visit. In adult patients, test for lipid disorders at least annually and as needed to achieve goals with treatment. Use aspirin therapy (75 to 162 mg/day) in all adult patients with diabetes and cardiovascular risk factors or known macrovascular disease. Current national standards for adults with diabetes call for treatment of lipids to goals of LDL $\leq$100, high-density lipoprotein (HDL) >40, triglycerides <150 mg/dL, and blood pressure to a level of <130/80 mmHg.

Monitoring/Tests of Glycemia

- In the correctional setting, policies and procedures need to be developed and implemented to enable CBG monitoring to occur at the frequency necessitated by the individual patient's glycemic control and diabetes regimen. (E)
- A1C should be checked every 3 to 6 months. (E)

Self-Management Education

Major Components of Diabetes Self-Management Education

Survival Skills

- Hypo-/hyperglycemia
- Sick day management
- Medication
- Monitoring
- Foot care

Daily Management Issues

- Disease process
- Nutritional management
- Physical activity
- Medications
- Monitoring
- Acute complications
- Risk reduction
- Goal setting/problem solving
- Psychosocial adjustment
- Preconception care/pregnancy/gestational diabetes management

Staff Education

- Include diabetes in correctional staff education programs. (E)

Alcohol and Drugs

Patients with diabetes who are withdrawing from drugs and alcohol need special consideration. This issue particularly affects initial police custody and jails. At an intake facility, proper initial identification and assessment of these patients are critical. The presence of diabetes may complicate detoxification. Patients in need of complicated detoxifications should be referred to a facility equipped to deal with high-risk detoxification. Patients with diabetes should be educated in the risks involved with smoking cessation should be provided as practical.

Transfer and Discharge

- For all interinstitutional transfers, complete a medical transfer summary to be transferred with the patient. (E)
- Diabetes supplies and medication should accompany the patient during transfer. (E)
- Begin discharge planning with adequate lead time to insure continuity of care and facilitate entry into community diabetes care. (E)

Sharing of Medical Information and Records

Practical considerations may prohibit obtaining medical records from providers who treated the patient before arrest. Intake facilities should implement policies that 1) define the circumstances under which prior medical records are obtained (e.g., for patients who have an extensive history of treatment for complications);

2) identify person(s) responsible for contacting the prior provider; and 3) establish procedures for tracking requests.

Facilities that use outside medical providers should implement policies and procedures for ensuring that key information (e.g., test results, diagnoses, physicians' orders, appointment dates) is received from the provider and incorporated into the patient's medical chart after each outside appointment. The procedure should include, at a minimum, a means to highlight when key information has not been received and designation of a person responsible for contacting the outside provider for this information.

All medical charts should contain CBG test results in a specified, readily accessible section and should be reviewed on a regular basis.

Children and Adolescents with Diabetes

Nutrition and Activity

Growing children and adolescents have greater caloric/nutritional needs than adults. The provision of an adequate amount of calories and nutrients for adolescents is critical to maintaining good nutritional status. Physical activity should be provided at the same time each day. If increased physical activity occurs, additional CBG monitoring is necessary and additional carbohydrate snacks may be required.

Medical Management and Follow-Up

Children and adolescents who are incarcerated for extended periods should have follow-up visits at least every 3 months with individuals who are experienced in the care of children and adolescents with diabetes. Thyroid function tests and fasting lipid and microalbumin measurements should be performed according to recognized standards for children and adolescents in order to monitor for autoimmune thyroid disease and complications and comorbidities of diabetes.

Children and adolescents with diabetes exhibiting unusual behavior should have their CBG checked at that time. Because children and adolescents are reported to have higher rates of nocturnal hypoglycemia, consideration should be given regarding the use of episodic overnight blood glucose monitoring in these patients. In particular, this should be considered in children and adolescents who have recently had their overnight insulin dose changed.

Pregnancy

Pregnancy in a woman with diabetes is by definition a high-risk pregnancy. Every effort should be made to ensure that treatment of the pregnant woman with diabetes meets accepted standards. It should be noted that glycemic standards are more stringent, the details of dietary management are more complex and exacting, insulin is the only antidiabetic agent approved for use in pregnancy, and a number of medications used in the management of diabetic comorbidities are known to be teratogenic and must be discontinued in the setting of pregnancy.

Summary and Key Points

People with diabetes should receive care that meets national standards. Being incarcerated does not change these standards. Patients must have access to medication and nutrition needed to manage their disease. In patients who do not meet treatment targets, medical and behavioral plans should be adjusted by health care professionals in collaboration with the prison staff. It is critical for correctional institutions to identify particularly high-risk patients in need of more intensive evaluation and therapy, including pregnant women, patients with advanced complications, a history of repeated severe hypoglycemia, or recurrent DKA.

A comprehensive, multidisciplinary approach to the care of people with diabetes can be an effective mechanism to improve overall health and delay or prevent the acute and chronic complications of this disease.

Definitions:

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Supportive evidence from well-conducted cohort studies:

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C

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- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Ongoing diabetes therapy is important in order to reduce the risk of later complications, including cardiovascular events, visual loss, renal failure, and amputation. Early identification and intervention for people with diabetes is also likely to reduce short-term risks for acute complications requiring transfer out of the facility, thus improving security.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This document provides a general set of guidelines for diabetes care in correctional institutions. It is not designed to be a diabetes management manual.
- Evidence is only one component of clinical decision-making. Clinicians care for patients, not populations; guidelines must always be interpreted with the needs of the individual patient in mind. Individual circumstances, such as comorbid and coexisting diseases, age, education, disability, and, above all, patient's values and preferences, must also be considered and may lead to different treatment targets and strategies. Also, conventional evidence hierarchies, such as the one adapted by the American Diabetes Association, may miss some nuances that are important in diabetes care. For example, while there is excellent evidence from clinical trials supporting the importance of achieving glycemic control, the optimal way to achieve this result is less clear. It is difficult to assess each component of such a complex intervention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

In recent years, numerous health care organizations, ranging from large health care systems such as the U.S. Veteran's Administration to small private practices have implemented strategies to improve diabetes care. Successful programs have published results showing improvement in process measures such as measurement of A1C, lipids, and blood pressure. Successful interventions have been focused at the level of health care professionals, delivery systems, and patients. Features of successful programs reported in the literature include:

- Improving health care professional education regarding the standards of care through formal and informal education programs.
- Delivery of diabetes self-management education (DSME), which has been shown to increase adherence to standard of care.
- Adoption of practice guidelines, with participation of health care professionals in the process. Guidelines should be readily accessible at the point of service, such as on patient charts, in examining rooms, in "wallet or pocket cards," on personal digital assistants (PDAs), or on office computer systems. Guidelines should begin with a summary of their major recommendations instructing health care professionals what to do and how to do it.
- Use of checklists that mirror guidelines have been successful at improving adherence to standards of care.
- Systems changes, such as provision of automated reminders to health care professionals and patients, reporting of process and outcome data to providers, and especially identification of patients at risk because of failure to achieve target values or a lack of reported values.
- Quality improvement programs combining Continuous Quality Improvement (CQI) or other cycles of analysis and intervention with provider performance data.
- Practice changes, such as clustering of dedicated diabetes visits into specific times within a primary care practice schedule and/or visits with multiple health care professionals on a single day and group visits.
- Tracking systems either with an electronic medical record or patient registry have been helpful at increasing adherence to standards of care by prospectively identifying those requiring assessments and/or treatment

modifications. They likely could have greater efficacy if they suggested specific therapeutic interventions to be considered for a particular patient at a particular point in time.
- A variety of non-automated systems, such as mailing reminders to patients, chart stickers, and flow sheets, have been useful to prompt both providers and patients.
- Availability of case or (preferably) care management services, usually by a nurse. Nurses, pharmacists, and other non-physician health care professionals using detailed algorithms working under the supervision of physicians and/or nurse education calls have also been helpful. Similarly dietitians using medical nutrition therapy (MNT) guidelines have been demonstrated to improve glycemic control.
- Availability and involvement of expert consultants, such as endocrinologists and diabetes educators.

Evidence suggests that these individual initiatives work best when provided as components of a multifactorial intervention. Therefore, it is difficult to assess the contribution of each component; however, it is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of health care professionals.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Diabetes Association. Diabetes management in correctional institutions. Diabetes Care 2008 Jan;31 Suppl 1:S87-93. [15 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

American Diabetes Association - Professional Association

SOURCE(S) OF FUNDING

The American Diabetes Association received an educational grant from LifeScan, Inc., a Johnson and Johnson Company, to support publication of the 2008 Diabetes Care Supplement.

GUIDELINE COMMITTEE

Professional Practice Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Diabetes Association. Diabetes management in correctional institutions. Diabetes Care 2007 Jan;30 Suppl 1:S77-84. [15 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Introduction. Diabetes Care 31:S1-S2, 2008.
- Strategies for improving diabetes care. Diabetes Care 31:S44, 2008.

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

The following are also available:

- Diagnosis and classification of diabetes mellitus. Diabetes Care 2008 Jan; 31 Suppl 1:S55-60. Electronic copies: Available from the American Diabetes Association (ADA) Web site.
- 2008 clinical practice recommendations standards of care. Personal digital assistant (PDA) download. Available from the American Diabetes Association (ADA) Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on April 2, 2001. The information was verified by the guideline developer on August 24, 2001. This summary was updated by ECRI on January 29, 2002, July 29, 2003, May 26, 2004, March 18, 2005, March 17, 2006 and April 30, 2007. This summary was updated most recently by ECRI Institute on April 1, 2008. The updated information was verified by the guideline developer on May 15, 2008.

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